QUALIFYING LIFE EVENT FORM

Eligibility Approved by
Date
Effective Date
Processed by
Date

Return Form to:
COA Insurance Division
68 Mitchell St SW
Suite 2107
Atlanta GA 30303

USE THIS FORM TO ATTACH ANY REQUIRED DOCUMENTATION OR TO MAKE ENROLLMENT CHANGES.

Employee/Retiree Information (REQUIRED)

Last Name	First Name	Social Security Number		Telephone
Address	**City**	**State**	**Zip Code**	**Department (Active Employees)**
Active ☐ Retiree ☐	Fire ☐ Police ☐	General Fund ☐		

Change My Enrollment as Indicated Below: Dependent Information

Last Name, First Name	Sex	Social Security Number	Date of Birth	MED		DEN		VIS		PCP ID Number
				Add	Drop	Add	Drop	Add	Drop	

IMPORTANT: Any Dependent listed above must meet eligibility requirements listed in the Enrollment Handbook. Eligible Dependents are: Your Spouse/Domestic Partner and unmarried children 18 and under. Unmarried children age 19-26 may be covered only if they are enrolled as a Full-Time Student in an accredited school. The certification form must be from the registrar office or from www.studentclearinghouse.org. Certification is required to add, delete or to continue coverage for dependents (FT-Students), please see Enrollment Handbook for details. If you do not enroll your dependent(s) within **31 days** of the qualifying life event then the next opportunity to enroll your dependents will only be during the Open Enrollment Period to be effective the following plan year.

Reason for ADD/Continue Coverage	**Date of Life Event**	**Reason for Drop (indicate below)**	**Date of Life Event**
Newborn ☐ DOB		Ineligible Dependent ☐	
Continue FT Student Coverage ☐		No longer FT-Student ☐	
Marriage ☐ Domestic Partner ☐		Divorce ☐	
Add A Child ☐		Dependent Obtained Coverage ☐	
Add Dependent Loss of Coverage ☐ (**You must provide a Certificate of Credible Coverage)**		Leave of Absence **w/out** pay ☐	

EMPLOYEE/RETIREE ACKNOWLEGEMENT & AUTHORIZATION

My signature below authorizes the City of Atlanta to deduct from my compensation any and all newly elected and or existing plan contributions for the above dependent(s). I acknowledge that by electing coverage for this dependent(s), I am authorizing deductions with respect to my benefits to remain in effect at least until the next Open Enrollment period or until I am able to make a change to my benefits as a result of a qualifying life event(s).

_____ _____

Employee/Retiree Signature Date